

**NOTICE OF RECONSIDERATION OF INJURY LEAVE RESTORATION**  
**April 1, 2000 through July 31, 2002**

This completed form must be returned within **10 working days** of receipt of this notice.

DATE: \_\_\_\_\_

TO: \_\_\_\_\_ SSN: \_\_\_\_\_

FROM: \_\_\_\_\_

---

**Department Use Only**

Facts (e.g., date, duration, and type of illness/injury):

Calculation (e.g., what happened and what should have happened had injury leave been applied in terms of time, month, or both):

Net Amount Owed by Whom (e.g., amount of leave and/or money owed to the state or employee):

Implementation Plan (e.g., repayment schedule, date leave will be restored, etc.):

---

**Employee Election**

- ☐ I elect to have injury leave restored to me as set forth in this notice. I understand that this is the full injury leave benefit to which I may be entitled for the work-related illness/injury covered by this notice. I further understand that any money I am owed by the state will be reduced by (1) any money I owe to the state and (2) any applicable deductions such as taxes and PERA.
- ☐ I decline to have injury leave restored to me for the work-related illness/injury covered by this notice. I understand that this is my only opportunity to make such an election.
- ☐ I wish to have my injury leave restored to me for the work-related illness/injury covered by this notice. However, I disagree with the department's calculations or implementation plan for the following reasons.

A. Reasons for objection to calculation of injury leave benefit:

I believe that the correct calculation of my injury leave benefit is:

B. Reasons for objection to repayment schedule of the amount of money owed to the state.

My proposed repayment schedule for the net amount of money owed to the state is:

**I understand that the decisions regarding my election could have legal consequences and that I may consult with my legal representative at my expense before signing this election.**

---

Signed

---

Date

---

Printed Name